

## IMMUNIZATION RECORD REQUEST FORM

The Massachusetts Immunization Information System (MIIS) is a web-based system that keeps track of all immunizations healthcare providers administer to children and adults in Massachusetts. The system was established in 2011 and is operated by the Massachusetts Department of Public Health (MDPH) according to state law (M.G.L c. 111, Section 24M; 105 CMR 222).

All individual information in the MIIS is kept confidential in accordance with applicable law.

The MDPH encourages that you request a copy of your immunization record directly from your current healthcare provider. However, you may also request a copy of your immunization record contained in the MIIS, in the form of an Immunization Certificate, from the MDPH. The Immunization Certificate includes your name, date of birth, age, gender, and immunization history (vaccine, vaccine type, and date administered) contained in the MIIS to date. In order to obtain your Immunization Certificate from MDPH, please complete this form and provide the following (please allow up to 10 business days for processing):

- A fully complete and notarized Immunization Report Request Form.
- A self-addressed stamped envelope to mail the record back to you; and,
- If you are making the request as a minor's parent or guardian, additional documentation demonstrating your legal authority to do so, such a copy of the minor's birth certificate listing you as the minor's parent
- If you are making the request on someone else's behalf, additional documentation demonstrating your legal authority to do so, such as an authorization to release that person's information to you.

**\*Please note – the Immunization Certificate generated from the MIIS may or may not be a complete representation of the most current immunization status.** According to Massachusetts state law, healthcare providers and other licensed professionals must report administered vaccinations to the state; however, it is possible your provider has not yet: a) been registered to use the system; or, b) entered complete immunization history into the system. **Therefore, MDPH may be unable to provide you with an Immunization Certificate or may only be able to provide you with a partial record.** In this case, you will have to contact your healthcare provider to obtain your immunization records.

You may also request a record of who has accessed your MIIS information. In the case of a minor, the minor's parent or guardian may request a record of who has accessed the minor's MIIS information. In order to request this record please complete a MIIS information Access Record Request Form.

**Please return the completed form to MDPH by mail:**

Massachusetts Immunization Information System (MIIS)  
Massachusetts Department of Public Health, Immunization Division  
305 South Street, Jamaica Plain, MA 02130  
**Phone: 617-983-4335**

## IMMUNIZATION RECORD REQUEST FORM

**Information on Record being requested:** This information is necessary to ensure the identity of the individual whose record is being requested (*i.e. you, your child, or individual over whom you have legal authority*).

NAME: \_\_\_\_\_  
LAST FIRST MIDDLE

DATE OF BIRTH:   /  /   GENDER: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_  
MM/DD/YYYY

ADDRESS: \_\_\_\_\_  
STREET CITY STATE ZIPCODE

MOTHERS MAIDEN NAME: \_\_\_\_\_  
IF AVAILABLE FOR INDIVIDUAL YOUNGER THAN 18 YEARS OF AGE

**Information on Requestor of the record:** This information is necessary to ensure the individual/agency has the legal authority to complete this record request. Please include documentation as appropriate to confirm legal authority.

Requestor same as above – skip to **Signature of Requestor**, otherwise complete section below.

NAME: \_\_\_\_\_  
LAST FIRST MIDDLE

ADDRESS: \_\_\_\_\_  
STREET CITY STATE ZIPCODE

RELATIONSHIP TO THE INDIVIDUAL NAME ABOVE: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

**Signature of Requestor:** This acknowledges that under the penalties of perjury that the information provided regarding your authority to request the identified immunization record is true to the best of your knowledge.

I authorize the Massachusetts Department of Public Health to release the requested record to:

SELF                       HEALTHCARE PROVIDER                       SCHOOL                       OTHER AGENCY

AGENCY NAME: \_\_\_\_\_ VIA FAX: \_\_\_\_\_

AGENCY PHONE: \_\_\_\_\_

VIA MAIL: \_\_\_\_\_  
STREET CITY STATE ZIPCODE

*Signature should be left blank and signed in front of the notary.*

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**Verification:** To be completed by a certified notary public.

STATE OF \_\_\_\_\_  
 \_\_\_\_\_ County, ss.

OFFICIAL SIGNATURE AND SEAL OF NOTARY:

On this \_\_\_\_ day of \_\_\_\_\_, 20\_\_,  
 before me, the undersigned notary public,  
 personally appeared \_\_\_\_\_  
 proved to me through satisfactory evidence of identification,  
 which were \_\_\_\_\_, to be the person whose  
 name is signed on this document in my presence. And has produced  
 documentation to confirm legal authority if requesting on behalf  
 of another person.

\_\_\_\_\_  
 Notary Public

Commission #

My commission expires